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Paul T. Lloyd Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH PAUL T. LLOYD, D.O. (CLASS OF 1923)
by Spencer G. Bradford, D.O. (Class of 1942) for the
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BRADFORD: We're speaking today with Dr. Paul Turner Lloyd, Professor Emeritus of Radiology and for many years Chairman of that Department. I feel that Dr. Lloyd has a great deal of valuable information to offer us about the history of the College, and perhaps some ideas about its future that may be a benefit. For a little background, I'd like to ask you, Dr. Lloyd, about your birth place and how you developed your interest in the osteopathic profession.

LLOYD: My interest in osteopathy began when I was in high school, really. Perhaps towards the end of that long session in school, because of an athletic injury and so forth and so on, which became a puzzlement for many of the fine physicians and surgeons in the Deposit/Binghamton area -- New

York City, also. The conventional medicine and surgery seemed to not be able to solve the problem. Later on, prior to having intention to study the healing arts in one way or another, I did come to know three fine osteopathic physicians, and after having gone through this protracted two-and-a-half year disturbance, and getting no relief, but going through the nearly two years in the Army in World War I, and after that, then coming in contact with these osteopathic physicians, the whole problem was solved with one osteopathic treatment.

SB: One treatment?

PL: That's right.

SB: That's incredible.

PL: I'm not going into detail on this, but it cost me over two years of really good, healthy study in Deposit High School, which was a splendid school at the time, and it had an excellent record with the New York State Board of Regents. At that time the Regents was about as good as you could get in

education at that level across the country. In any event, this one experience changed my plan for a future, and as a result of it, I came to the Philadelphia College of Osteopathy in the fall of 1919. The College was then located at 19th and Spring Garden. The College was there and I had the deanship of Arthur M. Flack, Sr., who, in his own way, was a tremendous person, both as a physician and as a head of faculty.

SB: Dr. Flack was a pathologist, was he not?

PL: Yes, he was, basically. But he was also a very splendid and accomplished general physician. I might say at this time that he gave a course which was perhaps unusual in terms of the application of applied osteopathy. This was a course in applied anatomy, really. To trace the pathways from the vertebral level to the various other visceral and symptomatic components. That was a startling course and he was a splendid lecturer. No one ever missed his classes.

SB: That in itself is a tribute. [laughs] Your recollections of other faculty members at that time -- could you tell us something about those?

PL: Well, yes. I'll single out a few. I think to go through the whole faculty would perhaps be a little too much to put on tape or in record. But, for example, in anatomy there was a very wonderful anatomist. Particularly at dissection and room level -- Dr. Henry Windsor. He was from a very responsible Main Line family, had secured his M.D. degree I think at the University of Pennsylvania, and later on did extensive studies abroad. At that time he had matriculated and was in the Class, I believe of 1920 or 1921 -- I think 1921 -- securing his D.O. degree. He also served as principal anatomist in the disection room area or laboratory, if you care to call it that. Windsor did some great work on the vertebral column and the study of the changes in the column due to minor as well as major curves or curvatures, and went so far as to uncover

the cord and study the vascular situations in area of major curvature deviations. Taking note of what he then called and was commonly called osteoarthritis of the spine. Actually, it's degenerative vertebral phenomenon, as we now know it, with spurring and marginal osteophytic changes in the bodies adjacent to the discs. But Dr. R. McFarlane Tilley spent nights down there with him, and I also -- as he did these dissections --

SB: For the edification of our listeners, Dr. Tilley subsequently became Dean at Kirksville. Am I correct?

PL: Oh, yes.

SB: And is now in an editorial capacity with Osteopathic Annals.

PL: He was. I don't know that he still serves there at the moment.

SB: I believe he still does.

PL: But in any event, in addition to that, Dr. Tilley had many other accomplishments and contributions to

the profession, and we were classmates. This is the Class of 1923, of course. But in any event, Windsor published his findings in the New York Medical Record and Journal, which was a very fine periodical at that particular time. Also, Windsor prepared a paper on his spinal findings. As a matter of fact, he published three different articles that I know of, and established in his own mind, no question that these variations in the vertebral column had an effect upon the vascular supply to the spinal cord, and also, the attendant changes upon the vertebral column itself, in terms of the disc and so forth and so on. But he prepared a paper to go back here a ways on his findings, and presented it before the Philadelphia Medical Society. But it wasn't well received, and he was refused privilege to print it in the journal here -- the local publication -- as well as to continue his further work and give further reports to them on his additional studies, which were completed along this line in the animal

experimentation lab of the Division of Surgery or the Department of Surgery at the University of Pennsylvania. I'm quite sure that the record I'm giving you regarding this fine and wonderful person is substantially correct, or perhaps further investigation of his life, particularly here at PCO, should be welcomed and in order. Then, other members of faculty at the time were Dr. Peter Berlin in physiology -- at least when I was there. Dr. Fritsche in chemistry, and perhaps the wheel horse during our first year, at least, and into our second year -- so far as faculty is concerned, is Dr. Edgar O. Holden, who later became Dean of the college on completion of Dr. Flack, Sr.'s tenure as Dean. Dr. Holden presented in lectures and laboratory work, physics, some chemistry, in conjunction with Dr. Fritsche. Also, histology, and perhaps one or two others, which I've forgotten.

SB: And all of these faculty members conducted their practice besides, I understand.

PL: Oh, yes. Dr. Holden was then a student, you see? He didn't receive his degree until 1922, I think, having been interrupted by a two-year service in the United States Army overseas in World War I. In my first year, these were a few of the faculty members that we have that I recall rather well. Dr. Francis Jenning Smith taught anatomy. He later was the head of the Department of Anesthesiology. Assisting him was Dr. McDougall, Henry M. Bellew, who later graduated in the Class of 1922, I think. I'm a little rusty on the years, but I think that's close enough. There were others, of course, that we had during our first year. And then in the second year, we continued our basic pretty well, with others participating. Dr. Sarah Rupp in nervous anatomy and Dr. Lillian Bentley in didactics, and many others, of course. As you say, sharing their professional life, both at office and at college level, decided to be members. In the third year we then came into more of the special areas of study --

clinical lives. Dr. Muttart in the gastrointestinal disease, Dr. C. Paul Snyder in physical diagnosis. Dr. D.S. B. Pennock in surgery. Dr. Roy K. Eldridge in comparative therapeutics, a course that was most valuable. Comparing there are the osteopathic procedures in clinical practice as compared to the pharmacopeia and the materia medica of the old school. Dr. John Bailey did a special course in pediatrics, asthma in children and so forth and so on. He also conducted a hay fever clinic, which was attended by hundreds of children. After treatment, he usually took them en masse out into the fields and exposed them to the various pollens that were available. [laughs] I assume that was it. I never accompanied him on one of these field trips, so I can't be sure. Further, in the classroom, other members of faculty introduced us to the beginnings of clinical osteopathy. Always in this particular stage of our development, each classroom was supplied with a McManus Table. The class members

who were used as subjects were in -- whether it be Muttart or Dr. Paul Snyder or Roy K. Eldridge or John Bailey or any of the others -- Dr. C.D.B. Balbirnie was a great teacher for us. They demonstrated how to treat, for example, lobar pneumonia or heart problems -- heart disease -- and various other disease processes common to the public health and matters at that time. So then in the fourth year we did experience a good exposure in the clinics. A clinic set-up at 19th and Spring Garden was in the charge of Dr. Gustave Heckmann, a fine D.O. A graduate of Kirksville School, as I remember it. He was in charge of the clinic. After this next person's graduation in 1922, Dr. Foster C. True, who is now still continuing as a member of the Board of Directors here, at the school -- True was assistant to Dr. Heckmann, and he -- Dr. True -- conducted the private practice in Haddon Heights, New Jersey. So our practice then we were assigned usually full clinical attendance, expected to be

there every afternoon. The adult clinics were conducted Monday, Wednesday and Friday afternoons, and pediatrics and other specialty clinics Tuesday and Wednesday afternoon. Dr. W.O. Galbreath had established the eyes, nose and throat clinic at 1820 Spring Garden, one of two buildings purchased and adjacent upon the College property, which had been the prior residence of Mayor Reyburn, City of Philadelphia. The Hospital then -- a 60-bed unit, as I remember -- had been built and completed in 1918, I believe, which immediately abutted the College -- the Reyburn building. Between the Reyburn and 1820 was a second building interposed, which was a nurses' residence. Anyway, to get back and get on track again, the clinic was well supervised. Each student -- clinical service -- had his own individual treatment room, and our patients were assigned to us. So we had the same patients from day-to-day and week-to-week, until their discharge, or whatever. This provided a good

follow-up as to -- in our own minds -- as to what osteopathic manipulative therapy could do, and perhaps what it didn't do under our poor hands. But that was very carefully watched because Dr. Heckmann and Dr. True would make continual rounds from treatment area to treatment area and talk to the patients. And if the patient reported to them that he or she had no relief or failed to respond to treatment, then we would be required to show Dr. Heckmann or Dr. True or both of them, what we were doing, according to the prescription that they had prepared for this particular patient. They were very gracious and would tell us what we hadn't been doing correctly, or what we should do, rather. And in this way, I think we also appreciated what manual therapeutics amounted to. There were other clinics, Dr. Bailey's pediatric clinic I've referred to, and there were other pediatric supervisors present. I think Dr. Ira Drew was not there at the time. He was engaged in some other type of practice. I do

not remember now who might have been there, in charge. Dr. Agnes Medlar and Dr. Curran, two ladies, served as gynecologists, and later, of course, Dr. E.G. Drew took over that department. And he himself, of course, was a splendid teacher and a very astute operator at the surgical level. I can't now, without some priming, fill in very much. But I haven't begun to cover the members of faculty that did so well on our behalf.

SB: On the clinic load for the students, do you recall about how many patients a student would see in an average afternoon?

PL: Well, yes. I'd say perhaps in an average afternoon -- considering we had three days, now. Not every patient was seen three days during the week, but maybe once or twice a week, or three times, if necessary, depending upon the case. On recall, and I think I have some old records on this, but I don't have the exact numbers well at hand now in mind. I would say perhaps we had eight or nine patients in

an afternoon. And if our workload on one of those days was, say, below four or five patients, then new patients were assigned to us, and that was rather carefully recorded by the clinic office. We were also supposed to keep logs or records of these things, which we sometimes did properly and sometimes we didn't.

SB: I'm sure you were told you didn't. [laughs] How did your interest in radiology develop?

PL: That's sort of like topsy, I guess. It really happened after I had finished my second year at school. Back in New York State, I had the privilege of being encouraged and supervised there by a fine M.D. out of the University of Maryland Medical School in Hopkins by the name of Dr. Henry W. Wilcox. He was a person that I had known in a small town I grew up in. But here was probably a man who, today, would probably be a top internist. In his early days in practice -- in the early days, just before the turn of the century, after Roentgen made

his discovery, shortly after that -- maybe two or three years later -- Dr. Wilcox had a small portable x-ray apparatus manufactured by the Campbell X-Ray Company, and had it for his office purposes, and diagnosing fractures and such things. No fluoroscopy, just straight radiography of a very simple nature. It was through him that I became interested in radiology, and it was through him that I was able to continue later, after graduation, in the study of radiology in New York City and somewhat in Philadelphia, mostly in New York City. Being assisted then by Dr. Ulysses S. Kahn, a German, who studied his radiology under a famous German radiologist and teacher. Kahn came to this country -- became a naturalized citizen, and served well in the Army Medical Corps as a radiologist during World War I. Kahn was a very exacting person, as you might anticipate. He was strictly imperialistic, almost, in his requirements. He made it clear to me that if I wanted to be a radiologist, I would have

to study more physics. So that was, perhaps, the most requiring thing that reached me. You will bear in mind, Dr. Bradford, at that time, in-residence training generally was not what we know of as being today.

SB: Right.

PL: In the osteopathic profession, there was no such thing.

SB: There were internships?

PL: Oh, yes. I'm glad you mentioned that because internships at the Osteopathic Hospital at 19th and Spring Garden -- I think Dr. Mortimer Sullivan served in an internship and one or two others. Dr. Brookman -- Jack Brookman -- later, to practice for years in Albany, New York, did have time. I'm not sure it was a full year. But the rotating type of internship was not developed until the Class of 1923 graduated and then Dr. R. McFarlane Tilley, Dr. Harmon Y. Kiser -- the latter two are still alive. Dr. Tilley in Connecticut and Dr. Kiser in

Pennsylvania. And I, the third one, were selected from our class to be the intern class that year -- 1923/1924. Then the faculty-staff organization was such that we were provided rotating internships, including the clinical laboratory service, the osteopathic medical floor and the surgical floor and the obstetrical area. As interns, we did rotate around, so we covered all services. But the services were merged. We would have a mixture of cases, which we were responsible for, from the osteopathic medical to the surgical, to the obstetrical. The beds were not in great numbers. So instead of being assigned a whole period of time -- say three months on one service and then three months on another and three months on another, and three months on the fourth, which would be clinical, we sort of had this merged so that each one of us had cases assigned to us, on any one of these services.

SB: So at any one time, you could be concerned with

three or maybe four services?

PL: Right. And we could exchange, so we could have time off, and yet know something about the other man's cases, you see? And we would have a weekend each month off.

SB: A whole weekend?

PL: Yes. That would be from Friday night until twelve o'clock Sunday night -- or Monday morning. And this we did. It was a good experience. We learned a lot. The faculty staff were very patient with us and taught us many things about care of the patients who were not ambulatory by reason of illness. We learned beside techniques of treatment, and so forth and so on. But we also had to do our own laboratory work -- blood counts, urinalysis, spunum analyses, and so forth. Not complex as today, but time requiring. Dr. Charles Barber, whom I failed to mention -- a very fine physician and knowledgeable, conducted a fine and great practice in Ardmore, Pennsylvania. Many of our patients were Main Line

folks at that time -- many -- coming to the Hospital, through his fine care and so forth, as well as others. He and others used the Chairman of the Department as their consulting personnel -- physicians -- and kept it all within the profession pretty well, though there were many D.O.s who even then preferred to use the old school, until they became ill themselves and then they would come to the Hospital as patients.

SB: That hasn't changed, has it?

PL: No, it hasn't. Men don't change that much. That's right.

SB: I was looking at the class photograph of the Class of 1924 just after lunch, a few minutes ago. Out of a class of about thirty-five, there seemed to be about fourteen women, so the trend toward women in the profession is nothing new. Am I correct?

PL: Oh, no. Women in the osteopathic profession have been there since the beginning of the school practice, really. Still drew no lines in

Kirksville. You didn't lay down lines between the sexes. Oh, no. We had many fine lady physicians. Bowles and [Ellastow] and Laughlin. I forget her first name now, and others. [Ellastow] in California, I knew very well. Bowles in Montana. But we had some outstanding lady physicians in the profession. Very good ones. And so in Philadelphia. I didn't know her -- I met her once. Dr. Jane Scott would be one, and I mentioned Dr. Rupp in neuro-anatomy. Cecelia Curran and Dr. Agnes Medlar. And numbers of others. You put me back on track with the interning. I've skipped a great deal about 19th and Spring Garden, which is filled full of -- I think, now -- good historical accountings that would, perhaps, be worthwhile in the complete history of the College.

SB: Did you have any contact with O.J. Snyder?

PL: Oh, yes. Yes. More so after graduation and in radiology. I shouldn't mention this -- it's never good to disclose what might be considered a private

matter between patients and physicians, but he did have his physical difficulties, and it required periodic x-ray examinations of the esophagus, stomach, gall bladder and duodena, and so forth. Prior to 1931, I think it was, when I first saw him -- and that would mark the end of our first year at 48th and Spruce. About 1931/1932 -- I'll put it there because I can't be any closer than that -- I did examine him and continued to examine him -- oh, say, about every year or year-and-a-half. Prior to that time, Dr. O.J. had been seen from the radiological point of view, by Dr. Henry K. Pancoast, at the University of Pennsylvania, who also lived on the Main Line and he and Dr. O.J. Snyder were very close friends. Dr. Pancoast was one of the four great men at that time in Philadelphia, who were recognized world-round as radiologists. The other three being -- as they called him Professor George Faylor and Professor Willis Menges -- Faylor being at the post-graduate

school at the University of Pennsylvania, as the Chairman of the Department of Radiology there, and that includes the Graduate Hospital. Professor Willis Menges, Jefferson Medical College, as it was then. Dr. Bowen, radiologist to the Pennsylvania Hospital at 8th and Spruce or 8th and Pine -- whichever you want to call it. And they, with Dr. Pancoast, became later known as "the four horsemen of radiology in Philadelphia," so designated by Professor Ross Golden, Chairman of the Department of Radiology, Columbia University Medical School, New York City, and Chairman of the Department of Presbyterian Hospital, Morningside Heights, New York City. Dr. Pancoast had been the one examining Dr. Snyder prior to the time that I saw him, and then to show you how nice he was to Pancoast, he suggested that since we had our own Department of Radiology, that Dr. Snyder might prefer to be seen there.

SB: [laughs]

PL: So this meant a collaboration of sorts between our

department -- then a very small department it was, but all right -- and the University of Pennsylvania. I can tell you something that might be of interest here. In 1926, when I came to Philadelphia -- August 15th of that year, at the request of Dr. Holden -- to take temporary charge of then the x-ray service. There was no Department of Radiology. It was a service functioning under the Department of Surgery. That had only been in being since about 1921, at 19th and Spring Garden. To go back to 1921, Dr. Dudley B. Turner, D.O. -- I think out of Kirksville for three years there, and his D.O. degree, and the fourth year at the Philadelphia School, to qualify for the New York State of Regents for licensure in Pennsylvania and New York. He wanted to practice in the State of Pennsylvania. He graduated from colleges of osteopathy, other than Philadelphia and Chicago. Those two schools were certified or, let us say, approved -- better word -- by the New York State Board of Regents, on the basis

of a four-year course and so forth and so on. So Dr. Dudley B. Turner -- I don't know how he came to be in this. There were many -- in those early days -- many general physicians had x-ray equipment. They weren't trained in it. They weren't trained in it.

SB: A little horrifying, isn't it?

PL: Well, I don't know how many people suffered as a result of it. I have a feeling they all use a modicum of good judgement. But in any event, Dr. Dudley Turner served as Roentgenologist or Roentgenographer -- you'll find this listed in the catalogs of the time. Various titles were given this sort of person. In any event, he stayed and practiced -- took care of the x-ray service, and practiced in town, as well, as a D.O., for about a year-and-a-half -- maybe two years at most -- I think more like a year-and-a-half -- during which time I think he gave two lectures before the junior class or something of the sort. X-ray,

generalizing, and then when he left to go into practicing -- I think in Williamsport, Pennsylvania -- upstate, anyway -- two brothers, Dr. Carl and Dr. George Ripley, mostly Dr. Carl Ripley, as I remember it, took charge of the department, and they provided service of sorts as Dr. Turner had. Mostly clinical work, and there wasn't much referral to the radiologist then from floor services. I don't know, but I experienced it later on. They continued to serve until 1924, and in the Summer of 1924, the Board of Directors of the College entered into an agreement with Dr. Charles Muttart, who, with Dr. Pennock, had private offices at 1813 Pine Street. Dr. Muttart and his radiological work -- he was particularly interested in the colon at that time -- had installed excellent x-ray equipment in his office, and had a fine and expert technician doing the work -- the radiological work. The technician was Mr. Burt Newman, who had been with the Victor X-Ray Corporation as a technical person and so forth

and so on, for several years, I believe. Well, anyway, the Newman-Muttart combination took over the department, or what then was called the x-ray section, still under the aegis of the Department of Surgery. That relationship continued until the summer of 1926, when the Board of Directors decided not to renew their contract with Muttart, and then for two or three weeks, there was no one covering service. I'd been doing some post-graduate work in radiology in New York City, and was home in Deposit, New York. I received a call from Dr. Holden -- a telephone call -- asking me to come to Philadelphia to discuss matters of importance with him, which I did at once. He asked me then to stay on and fill in the x-ray service until September, when the annual meeting of the Hospital Association and the faculty would transpire. I did this, and as a result, the faculty voted that I stay on, at least for a year. This was given an okay by the Board, and so I did stay on. Then, also, another year,

which I thought would have to terminate because I was supposed to then go to New York City to practice radiology in conjunction with Dr. Wilcox, who would do the general practice and whatever else was, and I would do the laboratory side of it. We had that agreement. But Dr. Wilcox himself developed larynx cancer, which ultimately, in a very short time, took him to his death. So I stayed on, and ultimately -- of course, Dr. Holden then did ask me to stay with the College, and I agreed to that. And so that was the beginning of what resulted in the development of a Department of Radiology. And that didn't come into real being until 1930, when we moved to 48th Street and had an enlarged department, adding one room to several rooms, and with additional equipment, which is already known about. That venture there was part of the million-dollar campaign conducted by the Board and faculty and staff and so forth, which provided the means for the construction and the equipping of the combined

College and Hospital at 48th and Spruce. The Department of Radiology was furnished through a gift by Mary Louise Curtis-Bok, the daughter of Curtis, of the Curtis Publishing Company fame, and so forth and so on. That is, in itself, another story. But then, the profession was so well thought out among the prominent people of Philadelphia that Atwater Kent, noted for the manufacture of radios among other things, and well-to-do in his own right. His gift served to furnish the Department of Surgery, and so it went. Anyhow, that's how the Department of Radiology really had its beginning, in a transition. I was going to say something here that I think you would be interested in. Perhaps you already know it. In 1926, when I came here, no hospital would cooperate with us in exchange of reports or films, nor were we privileged to have specialists in radiology and others, consult with us. A series of very interesting cases, funneling through the Department of Radiology at 19th and

Spring Garden, tended to change all of that thing. The case that I reported to you, I think, was an advanced cancer of the mouth.

SB: Yes.

PL: That was one. The consultant then was Dr. Bernard Pierre Wigman, graduate of Medico-Cli College, no longer in existence, and studying his radiology under Professor George Faylor, who is in charge of the Department of Radiology, not only at the Medico-Cli Hospital, which was the medico-chirugical college, no longer in existence. But the Hospital did survive and was functional at times, down on the Parkway. Having no one to consult with, let us say the teachers and chairmen and so forth, the select people, I turned to Dr. Wigman, in this case and in the case of Mr. Smith, who is the name of the patient we're talking about. As I told you, he was most gracious. I'd come to know Dr. Wigman, who, in exchange of patients from Osteopathic to Medico-Cli in the summer of 1924, and he remembered me,

fortunately, and was good enough to consult with me. And through him, I'm quite sure, this case was reported probably to the Roentgen Ray Society and so forth, quietly -- not an official thing. But it began to -- just a little bit -- break the ice, later fulfilled by several other cases where, for one reason or another -- and this was part of the history -- I don't know -- I guess it still goes on -- where the D.O.s received patients who had been seen by the old school for one reason or another, diagnosis had not been provided.

[end of side one, tape one]

SB: Dr. Lloyd, when did the residency program in radiology begin in Philadelphia?

PL: Well, as I recall, it was in the summer of 1928 that Dr. Holden called me to his office. He said to me something like this. He said, "I can foresee the development of many osteopathic hospitals, and in

order to have those hospitals properly staffed, we shall need specialists. I would like you to begin at once to formulate a program of education for physicians who are desirous of becoming radiologists." Well, this undertaking was quite a big one for me to think about, much less to -- or, perhaps more, I should say -- to plan. However, with the help of two of my former teachers in New York City, I did put together a program, but it was built around the graduate, rather than an undergraduate student participation. However, this is true that in September, a student came to us to the Philadelphia College, having had two years at the Chicago College of Osteopathy. And also he had been working, earning money for himself in Chicago, by carrying out certain simple duties for a private radiologist. This was Dr. Charles J. Curvo. He applied to Dr. Holden for some assistance, and said he would be glad to work whenever he might after college hours or whenever -- at night -- in the x-

ray department. This is how he and I came to know each other and he did, and he was an excellent student and enthusiastic about things radiological. He served two full years as, say, a student fellow. [laughs]

SB: This was before graduation?

PL: Oh, yes. Oh, yes. He learned a great deal about radiology as far as I can take him, at least, in those two years. And then he graduated as an intern, and during his intern year, he continued to be interested in radiology, and other service in that department therein, and the year after graduation, and the year after that, he also continued to study, but not whole-time here. He went from his internship to a small osteopathic hospital in St. Joseph, Missouri, and there started his department for that hospital. But he came back to Philadelphia during the summer months for additional studies. This really was a preceptorship. It wasn't a well-developed in-

residence program. As a matter of fact, that transpired -- the development of what might be called a rather well balanced program took several years to materialize. But after Dr. Curvo's graduation, Dr. Lucile Lumsden -- later Dr. Lucile Lumsden-Joslin -- she served as Secretary to the radiologist during her student years, and after graduation, spent some time in the Department and became really the second resident. Then came Dr. Carman Pettapiece, who spent a three-year residency. He was really number two, because Dr. Joslin, perhaps, would be -- that's right. Lucile Lumsden was second, and Dr. Pettapiece was really -- he spent three full years, and the fourth year in part-time, as I remember it, but daily attendance. He had sort of a fellowship year, and I must say how they did these things in those days I don't know because the stipend wasn't even good cigarette money.

SB: [laughs]

PL: But Dr. Pettapiece was followed by Dr. Kenneth Wheeler.

SB: Oh!

PL: Oh, yes. And Dr. Wheeler spent three full years as a resident, and then a fourth year, and then continued to serve perhaps a total of ten years as associate radiologist. The residencies then began to grow and develop and we were able to take two at the most -- three at any time at 48th Street because the service -- we didn't have room for them, and the service was limited largely by Department restrictions. The facilities and so forth and so on, together with also the limited number of beds that we had. I can't tell you right now off-hand what you wanted to know, in terms of the total number of residents, the total number of part-time students fulfilling their preparations for certification before the Board. Tutorials were included, and all that sort of thing. I don't know how many that we taught, but I will look it up and

have an answer for you in that respect pretty much when we go over this, finally.

SB: I think you'd be staggered yourself when you find how many, and how many hospitals you've seeded with Departments of Radiology. I can think of Detroit -- Dr. Karibo and the Maine Hospital -- I don't recall which one -- with Dr. Pettapiece.

PL: That's Portland Osteopathic. We had Dr. Rambo at Bangor. He was a part-time resident at the Department, and part-time with Dr. Fred Mowry in private practice. He was at Bangor. Then, later on, Dr. George Draper finished his residency here. He's still in charge of the Department at Waterville Osteopathic Hospital in Maine. Dr. Hobbs was a perennial tutorial person at Doctor's Hospital in Columbus. These men have gone on to -- they've had many more residents finish their fine studies than I did.

SB: But a great deal of it got started right here, I guess.

PL: Well, you could say that. That's a rather prideful thing to talk about, but you can become a little too egotistical and self-centered if you went that way, and that's not proper. Actually, if you have the right kind of student, and you have a program of instruction -- I mean by that almost didactic, as well as practical -- and you do that sort of type of effort -- perform it with decency -- then I think the resident almost teaches himself. While they weren't given carte blanche by any means because either I or Dr. Wheeler would come to sign the reports that went with the charts and so forth, and private cases were seen and diagnosed by us -- not by the residents. Outside referrals. We restricted the resident's work as the house staff should be to in-house cases by far and large, plus clinical work. Work of patients referred from the general clinics and so forth, as well as special clinics. They did have that privilege.

SB: Speaking of reports, I don't think that there are

many institutions in the country who issue reports in as much detail as we do here, and I don't think that anywhere else does the referring physician get a clearer picture of exactly what is going on in that patient.

PL: Well, maybe you and I will be biased in that regard. I agree with you. But I think it goes back to what -- to what I was exposed to. I was taught this -- that you described everything that is on the film or a combination of film plus fluroscopic findings, or whatever, to make a diagnosis. It wasn't a question of film reading, either. You have put together the clinical, the history -- the history first. The clinical findings, the laboratory. And if essential to the case, and there's been a pathologic opinion -- by the pathologist, that is. Not a pathological opinion, but the opinion of the pathologist. You take that, and merge this information with what is on the film, and then you should be able to make a diagnosis. That's no longer the practice by far and

large, at least in certain areas, because they put the films up and they read the films, and usually the reading is pinpointed to one or two things. The whole person as portrayed on the film is not referred to. It's taken to be average. You infer that -- something of that sort. So it was essential to make detailed reports -- long reports. And most often now, we'd be severely criticized by it because it's time-consuming. But that's giving the patient the value of the time, as well as the money spent in the Radiological Department. And a physician should feel that there was no great need to belabor a point that he might be interested in, other than the diagnosis that was made. It's in the report. We were severely criticized by this.

SB: Never by me. [laughs] I appreciated them.

PL: Many were. Many people did appreciate it. That's right.

SB: Did you ever get the feeling that the entire diagnostic puzzle was being dropped in your lap,

that the referring physician looked at you as sort of a God-like figure who would solve all his problems for him?

PL: I doubt that it was that serene on his part -- or spiritual. But, yes. I think we were logically to be leaned upon -- yes, I think that would be it. And that was welcome because it brought a general physician as well as a specialist together to discuss the case. The discussion that went on was helpful to the residents in the Department. And also to the house staff accompanying this surgeon or whatever -- interns or whatever -- as he made rounds in the Department. It was part of an educational system, in effect. You did it and many others did it. Some more regularly -- daily. Dr. Sterrett, Sr. would be regular, and many others. All of the faculty staff did cooperate in that way.

SB: You mentioned Dr. Sterrett, Sr. I believe you and he were fairly good friends.

PL: Very close.

SB: Would you care to reminisce about him?

PL: Well, I don't know whether reminiscing would be just exactly the way to look at it, perhaps, or perhaps it would. Yes. When I first went in the Department, Dr. Sterrett was then in charge of dermatology and syphiology -- a combination. And he was capable. But his interest, really, was in urology, and he secured that motivation or that interest by being in World War II, and attached to the Medical Corps, where he functioned under the supervision of Dr. Archie Dean, later professor of urology at Cornell University Medical School in New York, and also was assistant or associate urologist to Ben Berringer at the old Douglas Memorial, which was the Memorial Hospital, which is now part of the Sloan-Kettering Institute in New York. Dr. Dean helped Dr. Sterrett a great deal, and between Dr. Dean and another fine person at Memorial, Dr. Sterrett and I would -- I know I attended every Thursday morning, leaving here at seven o'clock --

on the seven o'clock train -- and frequently going by Dr. Sterrett, and we'd have breakfast on the train, and go to Memorial, and spend the entire morning and early afternoon at the Thursday morning conference and making rounds, and so forth and so on. Yes. Through his interests and my own, we then organized a weekly cancer conference at the College and Hospital, and we can talk about that later on, because that was the beginning of oncology, as it is now known, at our College. But Dr. Sterrett was a very accomplished urologist. He did some marvelous work, and I will tell you that he and the others of the faculty that existed in the late 1920s and 1930s, and up to World War II, not only taught it, but practiced manual therapeutics.

SB: I recall getting orders from Dr. Sterrett for OMT every fifteen minutes.

PL: Well, he didn't order that unless he thought it was necessary.

SB: No. And it was effective, as I recall.

PL: Oh, yes. He did some marvelous work with osteopathic procedure at both the private patient and the clinical patient level. There are records on that.

SB: I'm not sure I appreciated it as a student. [laughs] Because no sooner did I get finished, then I had to start again.

PL: Yes.

SB: But we had treatment around-the-clock on one patient that I can recall.

PL: I went through the very same thing, and so did Dr. Tilley and so did Dr. Kiser. We got that more in the lobarpneumonia cases. Not every fifteen minutes, to be sure. But around-the-clock, periodically. Maybe once every two hours or once every four hours, or whatever. But night and day, necessarily. You were working with desperately ill patients. Dr. Sterrett was faithful in his rounds. He would make morning rounds as regular as clockwork, and so would Dr. E.G. Drew. Some of the

others were not punctual in that regard. Dr. Sterrett would come to the Department of Radiology with interns and residents and so forth, at a time when he knew that we'd be through with our early morning thorascopies, and would then be in position to discuss cases with him.

SB: Another person I think who is not as well remembered as he should be is Dr. Edgar Holden. You've spoken briefly of Dr. Holden. Would you care to say anything more?

PL: Along what line?

SB: His degree and years of service. The amount of service he rendered.

PL: He was a far-sighted man. Excellent teacher. Just as excellent a student himself. Patient, quiet, and he had a characteristic that maybe he developed from Dr. Flack, Sr., or maybe it was just his own personality and his own knowledge and thoughtfulness, that he would listen to your complaint if you had one, or listen to a suggestion

or need of equipment or whatever, and they would say both he and Dr. Flack, so I'm told, would say about the same thing. "Well, I think you're right," or, "I don't know that I agree with you, but let me think it over, and I'll call you." Well, sometimes it would be one day or two days or three days -- maybe a week. You'd get the call and go to the office, and be sure they hadn't forgotten. They had it right down. Both men would say now in this instance, "Yes, I'll recommend what you have to offer, in need of equipment or whatever, to the proper committee of the Board, and I shall do it forthrightly." Or else, "I think we probably will have to put that on the shelf for time being." "We're not financially able to do it, or, "We do not have space to provide for it." Or, in rare instances, he would say, "I think it's not needed, and it's not a valuable item for us to further consider at this time." In their words, they were very diplomatic about this. They never seemingly

were rude or in any way obtuse or something of the sort. They always left the door open, and many times would reconsider later on, or, perhaps, a member of faculty wished or suggested it be done, or whatever. They were diplomatic and they were kindly people, and very human, I would say. I didn't serve as a faculty member under Dr. Arthur Flack. I think in the summer of 1924 was the summer Dr. Holden was inducted as Dean, and he continued then to further vitalize the development of faculty started by Dr. Arthur Flack, and that summer I received my first appointment to faculty as I finished my internship. As a matter of fact, the appointment preceded that -- the completion of my internship. That was June 15th, as I remember, 1924. But that was a mark that those two men set for others to shoot at, so to speak, and it continued. Dr. Holden continued to develop the faculty, and Dr. Flack was serving -- continued to serve on faculty, up until the time of his death.

SB: Another person who isn't mentioned too much in our histories -- he's not a physician, but I felt, as a student, that he was an integral part, was Louis Schacterle. At least he loomed rather big to me.

PL: Well, I think you probably have many others that feel the same way. Yes. No, he was not a physician. As a matter of fact, I'm not sure if he even had a college degree, which doesn't matter. I think he served a purpose, and it benefitted the school. There were other opinions that had been offered, but it seemed to me that he did serve a purpose. Yes. He and Dr. Dressler were very close, and Dr. Dressler succeeded Dr. Holden as Dean, and so forth and so on. I can't go farther than that. My relationship with Mr. Schacterle was not that extensive. Not at all.

SB: What do you see as some of the milestones -- some of the outstanding events of development of our Hospital and College?

PL: I think the progress that was made is a startling

one for a professional school and its hospital. The College should be the dominant factor, to my mind. This College is the result of an effort on the part of individuals in the profession itself. All the colleges were started in a similar fashion. There were no grants or anything of the sort, or legislation to support the development of the osteopathic colleges on the one hand, creation, or their hospitals on the other, until later on in the affairs, perhaps in the 1940s we began to get some support. But largely, it came just before World War II and afterwards. The hospitals developed more rapidly than colleges. We held to six colleges, I believe. California, Des Moines, Kansas City, Kirksville, Chicago and Philadelphia. They were maintained. Early in the profession, back in the first or second decades of the century, many osteopathic colleges sprang up, and you know that. That's carried out in Booth's history very well. But those that I just mentioned were the ones that

were in existence when I came into the profession and to the school, and held well until recent years, when quite a number of new schools have sprung up. But you mentioned Dr. Holden, and he fathered -- really fathered -- the development of the American Osteopathic Hospital Association. In that effort, he was assisted by Dr. Ray Gilmore of Iowa, and Dr. Oral Martin, then of Boston, Massachusetts. Those three men practically spear-headed the whole business, and Holden was the real motivator, and from that then -- particularly during Dr. Holden's term as trustee of the AOA from 1934 to 1937. Then the Hospital Association became most active, and then from then on through to 1940, we developed the hospital inspection program, which I had something to do with. I followed Dr. Holden as trustee in the AOA from 1937 to 1940. This is again, Dr. Holden's contributions to the profession, which have long since been forgotten. There were many. He made many. And I might tell you, in retrospect, that in

1928, I was privileged to sit in the meetings of the American Association of Osteopathic Colleges, and that first session was in Denver, Colorado in 1927, and more so in Kirksville in 1928, and then there were present Dr. Bonjardine out of Harvard, originally. A fine teacher and an excellent physician. He was either President or Dean -- I think Dean of the California school. Maybe President -- I'm not sure -- of the Board, and so forth. But then Peach from Kansas City, Dr. Peach. Dr. McVaine from Chicago. Dr. George Laughlin from Kirksville. From Des Moines came Dr. Arthur Becker -- great President. These were all great men. And Dr. Holden from Philadelphia. I learned a great deal from these men. I ran errands for them, from the House of Delegates back to the meeting and so forth and so on, which I enjoyed. It was a good education for me. Bonjardine and Holden were close together. That could be misinterpreted by certain people who later described the Philadelphia

situation as being the frozen East, or whatever. I suppose rightly some of the things but not a great seriousness, I hope. These were great days. Great days. The profession was on the move and in the making.

SB: Do you think we're still on the move?

PL: Yes, I do. But I'm not sure that all of our movements are forward. I don't mean that critically because I'm not in position to be judge and jury -- I'm not. Yes, I think particularly so -- I think we underwent a great movement of sorts, and yet, more than ever did the solid core of the profession stand up and be counted and hold the line during 1960, 1961, 1962, 1963, and maybe even still to this time, when there was a movement to follow California and amalgamate with the old school. Yes. I think that was a time of decision, and we found out that the profession was good and solid, in the inner core at least. I think where you're leading me is an area that I am not certain about having my feet on ground

-- how many of the vast number of students we now take care of in our college who are actually in a position to decide for themselves if they want to be D.O.s, as you and I understand that degree and what it means. I'm not certain about that. You get mixed opinions as you talk across the faculty -- what other men on faculty -- knowledgeable people, great teachers and interested and devoted to the College here -- how they will talk, or if you go outside to other schools and talk to some of the very substantial members of faculty who are D.O.s. We'll have to wait and see what's going to transpire here, I guess. I'm not certain, Dr. Bradford.

SB: I'm not asking you for a crystal ball opinion.

PL: I imagine if I pinned you down, you might have some reservations, also.

SB: Yes.

PL: And yet the students that I'm now privileged to meet once or twice a week over Dr. Meals' department are just fine people, by far and large. How well

they'll turn out to be D.O.s, I don't know. They'll certainly be physicians, I guess. [laughs] I hope they're physicians, and not just doctors.

SB: How do you draw that distinction? I think I know, but I'll ask anyhow.

PL: Oh, I think we can rub that off very easily by saying, "Anybody with intelligence might earn his degree, and be granted it in good grace and according to law by a school of the healing arts." But when you get into the osteopathic side of it, and begin to really study in the college years, the principles and the philosophies in back of our profession, and begin to appreciate how tissues and organs respond to properly applied manipulative forces and so forth, then I begin to wonder whether or not they're putting the knowledge of the -- well, say, for example, the autonomic nervous system to work, or the knowledge centering about the lesion complex. They'll understand very well, I think, today, the reflex phenomenon that might occur

-- say, from stomach to a certain area of the vertebral column and spine and cord and so forth. But I wonder how many could trace an impulse from the facet joint capsule to the sympathetic nervous system, including the ganglia, and so forth, and end up with an impairment of circulation at the stomach, the colon, the liver, or whatever. I'm not certain that that would be. Therefore, the importance of the facet joint lesion is not in their minds. Now, that may be not their fault. That may be in the program of instruction -- the curriculum for the school. It may be.

SB: Earlier you mentioned the fact that the instructors in most of the clinical disciplines had tables in the front of the room, prominently, and showed how the treatments were to be given for various ailments.

PL: Yes.

SB: Would you like to see that resumed?

PL: Oh, yes. Oh, I would. That was a requirement that

the school put into effect under Dean Flack, and later Dean Holden. They weren't straight tables, they were McManus devices. McManus tables. And later on we had also the addition of the Taplin table.

SB: I've used both of those.

PL: And to advantage.

SB: Yes.

PL: They're savers. In terms of the operator.

SB: That's right.

PL: And can be used to advantage where a straight table will not satisfy. I know this to be so. Sometime we can talk about George Taplin and the great man he was, and Dr. Rothmeyer, who is here, and is his assistant, you know?

SB: I wasn't aware of that.

PL: Oh, yes.

SB: I knew Dr. Rothmeyer, of course. I've seen him around.

PL: Oh, he was a fine anatomist, and he applied all of

that knowledge to his osteopathic treatment. Oh, yes. He was an expert with the Taplin table because of his close and long association with Dr. George Taplin, and in 1926 -- from then on -- for ten years, both the McManus people and the George Taplin people, with Dr. Rothmeyer, would be at the AOA conventions, and they'd demonstrate their table in treating the D.O.s in attendance on the convention. Oh, yes. Now, that isn't done today, is it?

SB: No. Is there anything else you think is important to add to this?

PL: I don't know that any of it is important. I'll leave that up to you. You haven't covered oncology yet, and I suggest we do it another time. I'm fast losing voice.

SB: I hadn't noticed, but if you'd like to do it another time, we'll do it another time.

[end of side two, tape one]

[May 14, 1980]

PL: Dufur, Balbirnie, Pennock -- most of them have been remembered in one way or another.

SB: The thing that amazed me about Pennock was the variety of surgery that he would undertake and do well.

PL: Yes. Yes, I think that is true. For instance, the first albi bone graft for childhood 's disease -- one of the first in the city was done by Pennock at 19th and Spring Garden, and the patient was Buddy Harkins, a nephew of Dr. Foster True's. The boy was perhaps eight or nine years old then, or something like that. Not anymore than that, I guess. He made a wonderful recovery. Dr. Pennock did a splendid job on him. It was the first one that had been done, too, of the albi type. And Foster assisted him. It was good. He could go from that end -- on the orthopedic side, perhaps, pretty well -- to such things as breast cancer and gastro surgery and so forth. Quite versatile.

SB: I recall at least one instance where he did some neurologic surgery, as well, on the brain.

PL: Who?

SB: Dr. Pennock.

PL: Let me think. Brain.

SB: This was in my student days.

PL: Brain, brain, brain. I can't recall anything at the moment -- any brain operations. I haven't any doubt of what he did, though I can't recall. The nearest thing to that that comes to my mind would be W.O. Galbreath and the mastoid region. I imagine Dr. Pennock did do some brain work, and I can't remember it -- I'm just lost on it.

SB: He was, I guess, a real mainstay of the institution in his day, though.

PL: Yes, he was. A mainstay in that field. But it has been reported that at that time, the D.O.s in Pennsylvania didn't have privileges where they might use morphine and other similar agents for relief of pain, and so forth and so on, and Dr. Pennock did

provide that to his M.D. degree. That's true. That happened.

SB: Well, heavens. I know when I graduated in 1942, I still wasn't clear on what I could do in the way of prescribing drugs.

PL: Right.

SB: It still hadn't been clarified.

PL: Right. I suppose that's true. Yes. I imagine so. Yes, I think that's so. That's the way things shaped up, and it was a continual battle, and since -- but call it continual progress on the part of the profession.

SB: Phenomenal.

PL: Oh, yes. Many difficult situations confronted those people in earlier years, and they did manage, very well, to meet the issues and resolve them nicely. The surgical bill is another example of that -- the right to practice surgery, and to have the Surgical Board -- or the Board of Surgery, to put it properly -- was created. Dr. Pennock served well then, as

Dr. E.G. Drew did, and others. He had the support of the valiant O.J. Snyder.

SB: Oh, yes. I admire O.J. in the way that he bowed out of his official connection with the College, yet never failed to support it.

PL: Oh, no. He bowed out so far as actual participation. Unless he was asked to. It was so nice the way he did it, and how he did it, after he would accept the invitation and respond properly. And all in good grace.

SB: This is a rare person.

PL: Right. Right. That's right. You're correct.

SB: I think of him every Sunday when I go to church because his former home is diagonally across the street.

PL: Oh. Is that so?

SB: Yes, I live in Narbeth -- that's his home of many years.

PL: I know. I used to go to his home once in a while.

SB: We were going to talk about developments in

radiology, and I think what you had in mind was, perhaps, equipment progress over the years.

PL: Oh, not necessarily. That would require practically a chronological listing to do that. The point -- perhaps it might be emphasized that throughout the Depression, after we were at 48th and Spruce Streets -- and things were so terrible, that Dr. Holden and Dr. Balbirnie were usually together, would have to take insurance policies and personal gains of that sort, let us say. Take them to bank -- in effect, loans, from a Northeastern Trust or whatever -- the bank -- in order to meet the payrolls, so to speak, usually until the fall class came in with tuition. [laughs]

SB: I have in the credenza here, a copy of the old ledger -- College ledger -- of those times, with records of repayments of loans that Dr. Holden had made. I couldn't decode them at first. I'll show you that later, if you like.

PL: I think I know. I went to several of these ventures

-- to the bank -- perhaps three or four, not to exaggerate, with Dr. Holden, and only once when he and Dr. Balbirnie went together, and I was, fortunately, included. I learned a great deal from this sort of thing. Mostly how difficult it was to keep things together, to go along. And they would. It was a yearly affair, you know? Mr. Harter, the President, I think, of the bank -- I think it was the Eastern or Northwestern Trust, or something like that. Not far removed from 19th and Spring Garden, which was the first one. Mr. Harter was -- I think that was his name -- President of the Bank. He was very much interested in the College, too. This made it a little bit easier for Dr. Holden to do this sort of thing. But he did it nearly every summer, I'm sure. And that continued on through 48th Street.

SB: That was unfortunate timing -- the 48th Street move in the face of the stock market crash.

PL: Well, you can look at it that way, and yet, maybe

something substantial came out of the -- what shall we say? -- tempering the metal in the profession by having difficulties, rather than having it all easy the things you have to work for. And let's say you struggle to get many times, you pride yourself -- well, that's a prize. That's something to hang onto. You've learned a great deal in the doing of the matter, too. So anyway, in so far as equipment is concerned, we were confronted with the same problem. For instance, we went there in 1930, and there was no what was then called "deep therapy apparatus" for the treatment of cancer and other diseases, and so, in 1931, despite the awfulness at times, we did manage to order a two-hundred-thousand volt apparatus from General Electric, and it was installed in 1932, and that was the beginning of things, such as oncology and that sort of business. It enhanced the Department, in terms of service. It was then a one-man department, which it remained as that in the strictest sense of the word until 1934,

when Dr. Wheeler graduated, had he came into residency there, in the department. And then stayed on for quite a number of years as a valued associate and friend and so forth. But during this whole time, there's a rapid turnover in radiological equipment. Oftentimes following a war, we experience this sort of expansion and development of new ideas and new things, and so forth. So it was in radiology. And oftentimes the money was not there, so it was Wood who responded, and go to the bank and take out loans and so forth, to buy new equipment. This implied not only x-ray tubes and cassettes and that sort of thing, but tables and major items essential to the service of a college and its hospital and clinics so that we could keep somewhat up-to-date. That continued right straight through, and it's been -- it's now in effect -- you see it now as Dr. Meal's fine department is enlarged so, and we're up-to-date. That's marvelous. But in the earlier days, it was not easy to secure the

equipment, though the cost would be -- oh, much, much less than the same type of equipment costs today. Quite awful how things have changed in that regard. I think every time we purchased a new piece of equipment, then the faculty and staff responded by doing new things. A good example of that would be perhaps in the late 1940s, we purchased a rapid film changer so that arteriography and cardiac evaluation could be carried out according to the trend of the times then. Dr. Arthur Flack was studying with Charles Bailey.

SB: This is the younger Arthur Flack?

PL: Yes. Arthur Flack, Jr., who, himself, was a marvelous surgeon. One of the finest ever developed in our profession. Arthur, Jr.

SB: He trained under E.G. Drew, as I recall.

PL: Yes, he did. Yes, he did. He had a good teacher, too, also, I'll tell you. But he, himself, had great abilities just suited for it. So, with this in mind, we purchased this piece of equipment, and

that provided not only Arthur Flack, Jr. for an opportunity to do cardiac catherizations, but also set the stage for Dr. Raymond Ruberg, in his developing years of neuro-surgery. These were great experiences, and both Dr. Flack and Dr. Ruberg enjoyed doing things beyond the range, perhaps, that a radiologist usually thought of. For instance, an example of that is Dr. Ruberg and I were interested in the circulation factor of the brain. Sure, you have the end artery system, and all that sort of business, you know? We came up with some good things, I think. Never published them. Findings, that later were proved to be true by authorities in the area of cerebral angiography. If we hadn't had that piece of equipment, these expansions would not have transpired. The equipment, as a matter of fact, was purchased well in advance, and months went by before we knew, except for experimental purposes, in the department. It found its place, and it was there for the faculty and staff to use and to expand

their techniques and their knowledge, and so forth and so on, and at the same time, servicing the public. Well, that happened right along. In many ways in the small Department of Radiology, which it was -- very small. Then it enhanced our in-residence program because the residents were intrigued with the fact that this did happen in the small department, and they could expand their knowledge and education. So it all worked out very well. The number of pieces of equipment that we had -- well, we used to accept them and be part of the game now. We don't talk too much about it, I guess.

SB: We were really in the forefront in the field of radiology, at least, rather than trailing along with a small institution.

PL: Well, let's say, this was generally recognized locally and outside Philadelphia, as well, that we were progressive. Yes. That's a good word to perhaps attach to it. It was a progressive college and hospital, and that was it. It was recognized by

the major old school institutions or hospitals and colleges here in the City, very well.

SB: What is your idea of what should be a good relationship between our profession and what you call the old school?

PL: Most friendly, cooperative. Certainly with understanding, but let each one do its own work and prove itself.

SB: I agree.

PL: We have to do that. We have not yet thoroughly satisfied the scientific community of the United States of our right to live. In part, we have. Get down to the real solid basic fundamentals, conceived by Still -- and carried on by his students, and so forth. No, we haven't solved some of the imponderables of the osteopathic lesion by any sense of the imagination.

SB: I agree, but it's a situation with so many variables that it's going to be very difficult to control.

PL: Yes, but why not solve one fundamental at a time?

SB: Except that they don't all exist.

PL: They don't all what?

SB: They don't all exist in isolation.

PL: Well, the fundamentals that you're talking about are there in mind and they should be there in substance.

SB: Oh, they are. But you cannot isolate one from the other, as I see it. So you have a situation with two variables -- two inevitable variables.

PL: I think you and I have differed on this before because at one dinner, over at the Presidential, Angus was sitting beside you and we got into some sort of discussion.

SB: Oh, I remember that.

PL: It was about the reflex lesion and I said, "Well, what comes first? Why is it necessary to have a reflex lesion present if the source of the disease has been properly cared for, and therefore, should not exist?" Basing that on the course of you can't compromise arterial supply and that sort of thing, but leaving your door open for such things as

trauma, environmental influences, occupation and whatnot, and so forth. But the fact remains -- today, the somatical visceral reflex is far better understood than the primary source of the pathologic phenomena, which might have origin in the facet joint. It's still not taught, and I think not well understood that the facet joint capsule itself, which is either two or three layers in thickness -- two usually accounted for by the anatomist. There are very few teachers that will point out the fact that at birth, the [ ], the yellow elastic ligament from lamina to lamina, from the second cervical arm down, to the lumbo-sacral level is intra-spinal, it has a particular importance in physiology in the vertebral column, and that the ligamenta flava at birth covers entirely the outer fibrons layer of the facet joint capsule.

SB: I didn't realize that.

PL: Well, you remember -- you can look it up and it will be recorded.

SB: There was some early research done -- radiologic research done, I believe, into the osteopathic lesion that might be of interest.

PL: Here?

SB: Yes. Or on 48th Street, or wherever.

PL: Oh, yes. That all started in July of 1930, when the AOA convention was here, in Philadelphia, and you remember that the College then was in its first year at 48th Street, and this attracted a great deal of attention. It brought many people to the meeting. Yes. It so happened that the radiological section of the program involved several people, and I happened to be the Program Chairman for it. Earl Hoskin, from Chicago College, was there. He was on the program. And Dane L. Tasker from Los Angeles. I'm not sure that Dane was on faculty or not, but he had been. Anyway, he was on the program. He was doing radiology in one of the hospitals out there in California. Earl Hoskin was in private practice, but also served the Chicago Osteopathic Hospital.

I'm not sure of his title on faculty. I can't remember that. But he was part-time faculty -- I knew that. But anyway, our hospital being new, and radiologists like other segments -- freshmen would sort of gather together -- the three of us met every afternoon in the small department on 48th Street, and talked shop. Earl Hoskin then was launched out on his study -- radiological studies -- of posture, and had come out with his first assembly of cases having to do with the standing x-ray film and the development of his findings referable to the short leg. Well, the standing x-ray film had been used before that. There are records on that. But not in the application that Hoskin gave it. This was purely original with him. Though Schwab shared with him somehow in this, I don't know from a clinical approach or what. But anyway, quite naturally, Earl was bent on that sort of thing, and the importance of it, because they had come up with somewhere around fifty-two percent of their patients had

measurable differences in extending length. And he was working at it solely from the posture point of view. But he had also gone into posture. For instance, how people would sit at their automobile, and the effect of the armrest, for example, on the position at the wheel, and how it might influence the vertebral column and so forth and so on. He was a general posture-effect man. We got into this, and Dane Tasker disagreed. He didn't think it was worthwhile. I, if you'll pardon the pronoun here -- I don't care to use it very often, but I have to in this instance -- I shared with Earl the importance of it. So by the time the meeting closed and the last day were there, Earl and I were together, alone, Dane having gone back to California. I said to him -- he urged me to institute this sort of thing at the College. I said to him, "Well, why can't we combine, and you continue the posture work, and if you think it well for me to indulge in studies of the vertebral column so far as the lesion

and mechanics are concerned." He said, "I wish you would do that." So this was our plan, and to extend it over at least a five-year period of time -- he and I. We did. But out of this then when I communicated this whole thing to Dr. Holden, he was so enthusiastic about it, he said, "Proceed at once." So we organized -- at least I did -- so as not to work at it alone, it would be not good. It looked like a team proposition. Got Dr. Fred Long, in osteopathic principles, and Dr. Charles Soden in principles and practice, Dr. Earl Gedney, who was a surgeon, also working with Soden in osteopathic principles and practice, and Dr. George Rothmeyer, Professor of Anatomy. This was the team, and it was oh so enthusiastically supported by Dr. Holden, that I think by the time we got the work going, to study first Hoskins work, we approached it exactly as Hoskins had, even to the positioning of the feet and the standing film, and so forth and so on, that we had great referrals from the clinic, and we used the

student body as control subjects and so forth and so on, and worked on just the standing x-ray film or films of the lumbar, spine, pelvis and worked on the short legs and so forth. Our findings approximated those of Hoskins and Schwab, so far as the percentage. In fact, I think we were a little bit higher. Maybe about fifty-four percent, or fifty-three and a fraction percent over what they had had found, as I remember it. And then out of this developed the first organized department of research in the osteopathic colleges, and that was Dr. Holden. Dr. Long alone started it. It wasn't until later that Guy Deming came into it. But William Tanenbaum, Mary Elizabeth Bailey and her sister and John Beckman and some of the others, out of the student body, worked with Dr. Long in getting his side of the thing set-up. And he originated many things. Pieces of apparatus for this sort of maneuvering, clinically. And developed the osteogram. That is copyrighted and still under his

name, you know?

SB: I didn't.

PL: Yes. And so forth and so on. And then, later on, as his research effort continued, and it was fundamentally sound because the first thing was to establish a means for measuring motion. Since it was held as one of the parts of the definition that there was not normal mobility in the lesion part because you had tenderness, muscle contraction -- that sort of thing. But motion was the test for motion, and we were taught to test for motion before diagnosing a lesion. When I was in school, this was a carry-on of that. So the first thing Long wanted to do was to establish a means to enhance so we could record motions in various segments and totally, down through the vertebral column, based on radiological finding. The reason for that -- the objective there -- has been lost to mind what this fine man had in mind doing. We hadn't gotten to studying side bend nor rotatory features. Just a

forward and backward motion, in terms of extension and flex. And largely, not through the facet joint rather, but across the range of the vertebral body and the intervertebral disc. If you study Long's -- well, it was a combined effort, but his idea of estimating segmental changes that somewhere along the horizontal plains of the vertebral bodies, the two lines -- the plains would meet and cross. And that was usually posterior, but could at times exactly come through the facet joint. Other times it would not be there. As you can see, these are available -- these reports -- even in the Library of Congress. Osteopathic medicine is there, among volumes of osteopathic medicine published by the school. The Libraries of Congress are aware, and Long's reports are in there -- some of them. And the methods used. So, anyway, that's how it happened. And then his department grew and grew and developed. It was healthy up until the time it changed into administration, and then everything

cut-off. That ended his research effort, but it was a good undertaking, and promised much for the future. It's too bad it had to stop, but it did stop, like many other good things. And so far as I know, it's not been picked up or carried on at all. But then, this led to the development of research, along these lines that some of the other schools -- notably in Kirksville -- and there, Dr. Denslow started that, as I remember. He should be getting credit for it. This was one of the first, I think, that could be ominously registered here at the school.

SB: A lot of that took place in my student days, so --

PL: That would be good for you to add to it, as you saw it and conceived it from the student approach. I think you mentioned the other day when we were together that not many abnormalities were found by Long. They're there.

SB: Well, he was dealing with "normal" subjects.

PL: Only in part. Only in part. We had clinic patients

who were not normal. But as I tried to tell you the other day, he had only begun, and never were the lumbar findings reported. We did these on lumbars, also. The one difficulty of the system that we're using would come to the vertebral area, where the physiological mechanisms are limited compared to the cervical area, lumbar, due to anatomic regions -- the facet joints come into it, and so forth, and the ribs, and rib cartilages and so forth and so on, which might influence the findings and particularly the clarity with which radiologists might be able to define the facet joints without very careful oblique films.

SB: That was part of the problem.

PL: We had that in front of us. We already experimented with enough so that we're going to do the lumbars next, in keeping the same system that held generally in the cervical area. And even had talked about using the cinema as a supportive measure -- motion picture. The kymograph, we had. We had the

Roentgen kymograph, so that we could register kymographic features. You didn't know this, did you?

SB: No, I didn't.

PL: We've never talked about it since some of the films were still available over in the storage area that Dr. Meals had kept. Some of those films are there. But the Roentgen kymograph, which are very good mobility features -- segment by segment, and you could stop it. We had the timoscope, where the Roentgen film placed in the timoscope, would exactly reproduce the fluoroscopic findings that you would see if you had a patient doing this under the fluoroscope. They had the timoscopes over there, the kymographs over there.

SB: I didn't know that.

PL: But I've extended this to the point to tell you, as an individual, since you are interested, how far the planning and research around osteopathic lines, had gone at the time of the cut-off.

SB: That was a monumental job, or would have been had it ever been completed.

PL: Well, that two letter word "if" comes into practice in our lives too often sometimes.

SB: Oh, yes.

PL: But I'm doing this in terms of trying to tell you in a round about fashion where Long and his colleagues had thought about things.

SB: Brilliant minds -- all of them.

PL: No. Well, he had a brilliant mind. As a matter of fact, he was a brilliant person. His writings tell you that, too.

SB: Yes. He served as Dean for a time, did he not?

PL: He was Dean Pro Tem. This was during the time before -- well, William Brandt served as Dean, and then later, I guess, as Vice President and then President. Fred Long did serve as Dean Pro Tem for a year or two. That's right.

SB: Then we had a hiatus with no single Dean for a time, until Sherwood Mercer came on the scene.

PL: Yes. Then the Dean's Committee served. [laughs]

SB: You were a part of that Committee, weren't you?

PL: Only for a short time. I sat for a time -- yes. Well, maybe a year, I guess. Maybe a little longer. I think I took Galen Young's place. Dr. Kenneth, Sr., in charge of physiological chemistry --

SB: I remember him well.

PL: And Dr. Rowland, and I think Dr. Victor Fisher sat in for a time. But Dr. Rowland and Dr. Fisher, and I met quite frequently, and tried to organize things, I think both pre-and post-doctor curricula. We arranged to try get things in order, and Victor Fisher came on and did a good job, too, along similar lines, as a member of that Committee, and served even after Dr. Mercer was here -- Victor did.

SB: Particularly in post-doctoral education.

PL: That's right. Yes, sir.

SB: I worked with Victor.

PL: Well, then, you know about it.

SB: Yes.

PL: I hope I'm chronologically correct.

SB: I believe you are. I also have some of the old bulletins and reports from the Division of Post-Doctoral Education, as it was then called.

PL: Yes.

SB: It's my feeling that Victor is another of the people whose contribution is not fully appreciated today, except by those of us who remember him.

PL: You're quite right.

SB: He was a quiet, unobtrusive person.

PL: Well, he and Herman Kohn had their difficulties together. They were united. But they had dislocations that I wouldn't want to experience. It could end the profession, which happens to many people, and disappointments -- let's put it that way. They were close together and worked valiantly in another fashion than what we're talking about today. Herman -- I don't know whether he'd care to talk about it today or not.

SB: Knowing him, probably not.

PL: No. He'd probably smile and say, "Oh, well, that's water over the dam. Let's not go into it," which it probably is .

SB: I think so.

PL: He has never forgotten his osteopathic principles and techniques, however -- Herman Kohn, I mean.

SB: Indeed, he gave a very fine treatment. I visited him in Florida about three years ago. I had a very bad cold at the time. I got an osteopathic treatment such as I rarely had in the past.

PL: Well, when it's done properly, there's nothing more effectual than a good scientific treatment. I don't know that. I don't know how many people are born to be able to do this. Did it ever occur to you that D.O.s of that sort are probably born and not made?

SB: I think some of them are -- yes.

PL: I do.

SB: But I think that any student when he comes in here is capable of learning to give an adequate osteopathic treatment.

PL: You're qualifying it by the word 'adequate.'

SB: Well, not everyone is a -- well, to use a theatrical word, a virtuoso.

PL: Paliacci says if you know how to use a diaphragm, you might be able to sing.

SB: [laughs] Well, we're not all Carusos, but we can all carry a tune.

PL: Yes, I try, of sorts. What else maybe can we indulge in this afternoon while we're together?

SB: Well, that's fairly well open. I wonder about your projections for our future here.

PL: I think you ought to cover something -- I believe you mentioned to me -- and that might be oncology.

SB: Oh, yes. Yes.

PL: Don't you have that down?

SB: I do have that down, and I think that's something that we've skipped over rather lightly.

PL: All right. This, in part, brings in, as far as I'm concerned, brings in a member of faculty -- a great person we talked about, Dr. Willard, Sr. When I was

in New York earlier, trying to make ends meet with radiology preparation and trying to practice it, I had the privilege of going to several hospitals, and so forth and so on. Later on, coming to the College here full-time, made possible association with others on faculty.

[end of side one, tape two]

PL: During World War I, Dr. Sterrett was associated with the military service. I think I mentioned this the other day -- the Medical Corps. By virtue of his initial interest in venereal disease and so forth and so on, he was assigned to the service of -- I think -- Captain Archie Dean, later a physician and specialist of prominence at Memorial Hospital in New York City -- Douglas Memorial, and part of the great staff that the Professor James Ewing had assembled to provide service for cancer patients, and so forth. Well, Dr. Sterrett and Dr. Dean maintained

their friendship, and I also -- about 1929, in the fall -- began to go to Memorial. I'd go to the Thursday morning conferences, which was about a two-hour conference -- from ten-to-twelve, something of that sort -- concerning, of course, patients on service in the hospital. It was very well conducted and a wonderful, wonderful staff and faculty. And this is a part -- if I remember correctly -- Douglas was part of the educational system at Cornell University Medical School. In any event, Dr. Archie Dean was an associate then to Dr. Benjamin Berringer, Chairman of the Department for Neurologic Surgery. Dr. Sterrett and I would go on Thursday morning -- leave at seven o'clock on the early train, have breakfast on the train, and go over there. We would be invited to make rounds. Sometimes -- not always, but sometimes -- we had the ample opportunity to learn much prior to the conference. And then for two hours -- ten o'clock in the small auditorium they had -- wooden benches

supplied free-of-charge, we'd attend the conference. The conference from week-to-week would shift from service-to-service. It might be urology today, gynecology with Dr. (Professor) Healy in charge. It might be gastrointestinal service with the famous surgeon -- I can't think of his name now. He's author of the three-volume work. George T. Pack was head of the gastrointestinal services. And so it would go. Well, as things developed there, I became rather close and quite friendly and, I say, very friendly, with Dr. James Duffy, the radiologist in charge of the four-gram teleradium treatment source. They called it the four-gram pak. Dr. Wright would go to the conference with Dr. Duffy. And there was an aisle down the relatively small conference room -- benches on one side and on the other. We always sat on the right-hand side, about four or five rows back. Dr. Duffy was beyond the aisle, and I'd be on his left, and on my left would be Dr. James Ewing -- Professor Ewing. This was wonderful for me, you

know? And on his left, Dr. Eloise Lesperance, the well-to-do lady who had a deep interest, of course, in the subject of cancer, and so forth. But she also set-up and created the first cancer detection clinic. As far as I know, the first in the nation. It's still in existence, and it was given the title of the "Strain (?) Prevention Clinic." She was a marvelous lady.

SB: What was her name, again?

PL: Eloise Lesperance. Now, I'll just depart here for a moment to tell you that if you ever observed, in earlier years on T.V., the horse show of Madison Square Garden, one of the greatest in the world. She was there with a beautiful four-wheel carriage and a horse or two, pulling it. Usually one. She would be so precise and sit there so beautifully and show that horse off. That was Eloise Lesperance. Well, in any event, here I was with a very wonderful man on my right, and over here perhaps the greatest authority on cancer and neo-plastic disease in the

country at the time, and not since then, Professor James Ewing. You'll have to edit this out because it will be offensive to some people. Invariably at that time, I did smoke cigarettes. Not very many during the day. One at a time, but not many during the day. But they were a cigarette made locally here, by the Russian Importing Tobacco Company. It was a delightful Turkish blend cigarette. I'd get them in packages of a hundred, and I'd have a small cigarette case. But there wasn't a morning as I think of it -- of course this is an exaggeration now -- that sometimes during the daily conference, Dr. Ewing would be in there and he'd say, "Dr., do you have an extra cigarette? This morning I left mine in my laboratory coat." And he'd say, "That's a splendid piece of tobacco." He had many little features about him that marked him peculiar. Delightful, though. I learned so much from him -- Dr. Bradford. For instance, I'll give you an example. A case might be presented and they

described how much treatment they've given him. Whether it was surgical, radiological, or both, or just radiological -- radiation therapy. He'd say, "Oh, you're not giving the patient a chance." Now think. "Give the patient a chance," he'd say. Once in a while it would irk him so he'd get up and question the people presenting the case in the conference generally, as to how much treatment should you give? In other words, you are neglecting the ability of the patient himself to control or attempt to control the cancer from which he's suffering. We hear it now, don't we?

SB: Yes.

PL: How the immune systems enter into this.

SB: Yes.

PL: Being reviewed again. Things like that that nobody else might here, except maybe Dr. Lester, maybe. And sometimes he'd talk to me about it. A little bit -- not much. Then, occasionally, Dr. Sterrett and I -- maybe Dr. Duffy or Dr. Dean, or once or

twice Dr. Ewing -- would come on and join us for lunch today. So after the conference, we'd go down into another nice room and nice area of the hospital, and have lunch, and then you could hear these great men talk.

SB: All informal?

PL: All informal. All informal. There might be a case -- one man would have and say, "I think you ought to see this patient," and so on and so on and so on. "I think I've done all I can. Now somebody else has to take over," or whatever it may have been. I'm not trying to quote now what they said, but the general tone was, "This is how we get together. This is how we do it. This is our idea of teamwork, and here the great Ewing is responsible for the whole thing."

SB: Is this the Ewing for whom the tumor was named?

PL: Oh, yes. The Ewing Carcoma.

SB: Yes.

PL: You'll find fortunately in the library -- I don't

know that they have the first and second editions, but I think you'll find Editions 3 and 4 of his work New Plastic Diseases.

SB: I've read it.

PL: Yes. Study it. You can pick that book up today -- no matter what tumor it is. Although, the terminology has changed, you see, in some instances they're different, in evolution. It's a textbook where he quotes so many people. He gives credit to so many people. There isn't a chapter that may not have many, many references of other people's experiences. And the difference of opinion between this man and that one. And then almost innocently he'll say, "My findings are so-and-so, never putting himself in the spotlight. This is another example of greatness, isn't it?

SB: That's true greatness.

PL: Well, anyway, this went on every Thursday morning, from October through the first of June. I didn't miss very many. Even when I was working alone, and

had only a resident or two -- usually one resident until about 1934 or 1935, and then we had double the residency -- even the resident-in-charge made sure nothing would be coming in until I could get back to covering -- usually about three o'clock in the afternoon. And that went on until World War II. I went back after World War II, and then that whole thing had changed. A new auditorium had been built prior -- just before World War II, with theater chairs and everything. Just wonderful. Dr. Ewing wasn't there. That, I think, was the great experience in oncology that I had. But anyway, back in 1930, coming home one afternoon, Dr. Sterrett and I said, "I think we ought to have a tumor conference in our Hospital -- College." He said, "Yes, I think so. I think we see enough cancer," and we do. We've always seen many, bed proportionate-wise. Bed-size-wise. We see an awful lot of cancer compared to other places.

SB: Would you hazard a guess as to why?

PL: Yes, but I'm not going to say it now because we're on tape. I don't want to hurt anybody's feelings. Anyway, he said, "Yes, I think we should." So I said, "All right. Let's go about it." And what better way than to copy the Memorial System of doing it? He said, "Good." I stuck a little bit out of character, I guess, and got permission from Dr. Holden, and I addressed -- by telephone, as I remember -- the National Cancer Institute in Washington, which was in its infancy at this particular time. I came in contact with a wonderful man who was Mr. Cancer Institute -- Dr. Ludwig Hectone. I told him who I was, where I was, and I wondered if he would receive me for audience, that I want to discuss with him a plan that we had for our cancer conference. He said, "Yes, I'll be glad to see you." Oh, just a wonderful person, I thought. He told me when to come down, and I went down, and then the Cancer Institute was one brick building, and I guess he was at the whole thing. Of course,

now it's expanded.

SB: Oh, God!

PL: But you'll see his oil in there, unless they've changed it. There's an oil painting in there. He looked at what I'd written and said, "I have nothing to suggest to it." I said, "Well, this is not original. This is based on Memorial in New York." He said, "Well, it's good of you to come down, but you didn't have to. Why didn't you tell me that." I said, "Well, I wanted you to pass upon it." He said, "No. Go to it. All good luck," or words of that effect. So I came back feeling sort of walking on air, and communicated with Dr. Holden. He said, "Yes, go ahead." So Dr. Sterrett and I did set it up, and I must say, it got off very well. Dr. Carlton Street, Dr. Arthur Flack, Jr., Dr. Leuzinger, Dr. Sterrett, even Dr. Karnig Tomajan was in for a meeting or two. He was, I think, still a resident then. I'm not sure. I think so. He was Chief Resident and others on the house staff. We

had the house staff there -- the interns and residents that could be spared came, and we met on -- I don't know whether it was Tuesday morning or Wednesday morning or Friday morning -- one of the mornings, anyway -- every week. Maybe it was once every two weeks to begin with, and then we began to meet every week, or something of that sort. We had a secretary. We elected one of our people secretary, and other than that, the radiologist usually got the conference under way. Dr. Dressler, would, at times, take charge, and so would Dr. Sterrett. But we had good meetings, and we covered our cases rather well. We really had some exciting debates at times. And this went on until World War II came into being, and then, I think, gradually it petered out, though I have some of the last -- at home, somewhere, I have them preserved -- a few of the reports of the secretary of the conference, Dr. Boyd Button. Do you remember Dr. Button?

SB: I remember Dr. Button.

PL: In his writing, and some of the cases covered, and we also covered some of the cases covered by the conference in the publication the College then entitled Osteopathic Medicine. I referred to that, and those volumes are in the Library of Congress.

SB: Yes. That was a publication of the late 1940s, as I recall. Mid-1940s.

PL: Mid to late 1940s. That's right. The publication continued, but our conference petered out because faculty was so split up during World War II. I think it maybe never recovered from it. After that, it went from 1941 to 1945, didn't it?

SB: Yes.

PL: The war. We did publish Osteopathic Medicine -- you're right -- after that time. Dr. Holden initiated that publication, when he was no longer Dean. He left the post at World War II, somewhere around 1943, wasn't it?

SB: I believe so. Yes.

PL: I think so. So that is the way the oncology thing

really began. And then after World War II, we started formal courses in oncology under that. It really blossomed -- that part blossomed -- mostly around 1950 to 1951, when the Health Education Welfare Department in Washington initiated the college support grants in cancer education, and the osteopathic profession participated. And now we're on to a little bit more organized program with a director of the program and the coordinator. Earl Riceman was the first Coordinator, and then, when he passed on, Dr. George Court became Coordinator, and when he later moved on to Florida to practice, Dr. William Barnhurst served for only two years, as I remember, and then he suffered an untimely death, and then I really served, I guess, as both Coordinator and Director. I was privileged to serve as Director from the beginning of that program, on. Then it prospered, and I think students left the school then, feeling more secure about the diagnosis, as well as the prevention of cancer, and

the care of the cancer patient. The cancer coordinators then organized themselves. That would include the coordinator of cancer in each of the medical schools, the old schools, the osteopathic colleges and schools or colleges, and the dental schools. The coordinators would be once a year to study how best to teach cancer. And out of that evolved the American Association for Cancer Education. The coordinators then formed the American Association, which is still very active and flourishing.

SB: This is independent of the American Cancer Society, then, or is it --

PL: It has no connection with the American Cancer Society directly. The two cooperate, and also there's close association between the American Association for Cancer Education and the National Cancer Institute as part of the Institute of Health in Washington. Now the Ewing Society is the Society or Association for Radiation Therapists, and the

Association for Cancer Education and several of these kindred bodies have united to form a group of scientists, and they have -- we're a part of it, through the American Association for Cancer Education combined scientists.

SB: So here again, we've been on the scene a long time.

PL: Yes, yes. We've been privileged to sit in and participate. One of the osteopathic college representatives has been -- well, several have been very active on committees of the American Association, and also for cancer education. And also, during the time of the Coordinators. One of those was L. Raymond Hall, a surgeon at the Chicago State College, and another -- a fine internist at the Chicago College -- do you remember his name?

SB: I don't remember.

PL: Oh, I'll think of it.

SB: I'm not worried about that.

PL: I'm not doing well with it. Oh, a wonderful person. Then a fine man representing Kirksville College, who

just recently died about two years ago. They were together with our representatives from here. They were the ones that usually met at these various meetings, and they had very good rapport with the old school and the dental people, as well. It was very fine, and I think much progress -- good progress -- resulted from both the coordinators meetings and the annual meetings of the American Association for Cancer Education.

SB: Do you feel that chemotherapy has changed the cancer scene a great deal?

PL: Oh, I'm not in a position to talk much about that. Oftentimes I think the effect on the host is more overwhelming than the total byplay of the cancer. But basically they seem to still be enthusiastic about it. They certainly have made advances through chemical agent therapy in such things as childhood leukemia, for example, and some others. But like everything else, it will ultimately find its own proper niche, and be like many other things that we

go so enthusiastically about using, and after a sufficient period of trial and error and tribulation also, many times, the agent or the agents themselves finally find useful, or else they go into the discard. In your time and mine -- well, Fleming's work with penicillin, for example. Take now the many, many synthetics that have come about, and all that sort of thing. Along this one line of thought, where mold -- if you care to call it that -- yielded an agent. The use of periwinkle flower, for example, in the treatment of lymphomas, and other malignant lesions.

SB: As I recall, Dr. Pennock was investigating mistletoe as a cancer agent.

PL: Well, William B. Kohler, Sr., whose son, W. Bradley Kohler, had the orthopedic service at Memorial when I was there. I knew Dr. Bradley. His father, William B., went back well before the turn of the century, a wonderful surgeon. I don't know whether you have ever come across the words 'laudable pus.'

SB: Oh, yes. Yes.

PL: This was in the days of laudable pus.

SB: Before Lister?

PL: I'm not sure if it was before Lister or after Lister. But surgeons apparently -- Dr. Wilcox recited this to me once or twice or three times, or whatever. "If they perform an amputation for a malignant tumor, and the amputation site became infected, they weren't despondent." This was the laudable pus business, and Cooley experienced it. Cooley, Sr. So he developed a vaccine. He developed this vaccine and used it in his tumor cases -- bone tumor cases, as I remember it. And he got some surprising results. Surprising in view of the fact that the sarcoma inevitably was a hundred percent fatal, you know in those days, and it's not too good now. [laughs] They've made progress, I will admit. And perhaps the so-called 'chemotherapy' set forth the play in it. Other things come into the picture, however, at the

moment. But anyway, that's where William B. Kohler -- how he came about, as I remember, to develop Coely's vaccine. There was another one of these things, which was Koch's vaccine, manufactured by a man who is, I think, from Detroit, Michigan. I may be hazy on this. But Dr. Pennock also used that -- I recall one case in the young lady -- the daughter of a D.O. -- that had a hemangioma of the gluteal region, and it grew and developed, and she was beyond the infancy age, where it should have progressively gotten smaller and so forth. They biopsied it and found it to be malignant. There was quite extensive lesion, and not a nice one to go into surgically. Dr. Pennock did operate on her, and then he asked me to get with her father to give her radiation or therapy because this theoretically, should be a radio-sensitive lesion, and it did respond. But he also then gave her one or two courses of Koch's vaccine. She got well and healthy and married and had children, and so forth. Can you

recall Dr. Manuel Jacobson, the pathologist?

SB: Yes.

PL: Dr. Jacobson had this theory. He developed a vaccine of sorts -- an injectable -- and tried it on quite a number of advanced cancer cases. Most of these patients were under radiation therapy. I had a chance to work with him quite a bit. We got along well together and enjoyed each other's company, particularly when we could argue.

SB: [laughs]

PL: Oh, yes. But friendly arguments we had. Nothing awful bad. His solution was not effectual. That doesn't mean that his idea wasn't a good one. He had been exposed somewhat to cancer up at the Crocker Institute in Columbia University in Morningside Heights. He was there, in the laboratory, if I remember, before he came to PCO. I had been up there with a fine radiation therapist, too, and so we had something in common to talk about. The radiation therapist was Francis Carter

Wood, who was then at the Crocker Institute, and also in charge of the Department of Radiology at St. Luke's Hospital in New York City. So, anyway, this went on. Now, there were other experiments in cancer. Use of colloidal lead. This would be back in the 1930s. Dr. Wheeler was there as resident. Dr. Floyd Trenary, a fine D.O. radiologist, most interested in radiation therapy and cancer, had his own office in Los Angeles, and also was one of the leading figures in the hospital there, which was served by Curtis Brigham and his brother, and the fine Lewis Chandler and T.J. Rutty (?), and various other outstanding people in the osteopathic profession. This constituted the Montesano Group at Montesano Hospital. Dr. Trenary had already been started. I think Oxner in New Orleans started this part -- the use of colloidal gold, and then someone else developed colloidal lead, and Trean Lacoucher (?) of Detroit was one of the leading users of colloidal lead. Hewitt Miller, Ph.D. was the

chemist who developed a colloidal gold solution, which could be given orally or (?) , and since it was of a colloidal order, it would be sensitive to take up by the lympathic system since the lympathic system has an affinity for colloid take-up. And then taken conveyed by the bloodstream and so forth, to the tumor site. Entering the tumor site, the differences in circulation and so forth -- the idea was that the colloidal lead would concentrate within the tumor of the tumor-bearing area, and these small, minute particles of metal -- the gold, in this instance -- would set-up targets to be hit by the primary photons. In other words, the radiation energy factor from the x-ray source, the radium or whatever, and set-up secondary centers or targets for secondary radiation, so that a homogenous radiation of the entire tumor might be secured. That, in part, was the theory in back of it. Floyd Trenary -- when he got this underway -- called me and also wrote me to undertake to use

colloidal gold on a series of cases -- whatever. I received permission from Dr. Holden to do so. Dr. Wheeler was there and he worked with me on it. We had some interesting experiences with it, but I doubt that we ever helped anyone too much in that regard. So these were given up largely later on by everyone, I guess. That was one experiment in cancer. The other one was the use of pink tincture of colchicum, then used in the treatment of gout, which was an agent, when absorbed into the body, would bring about a cessation of mitosis, and a temporary arrest, at least, of mitosis. And that is a sign when the cancer cells, as far as we know is most susceptible to radiation. Now this, I was invited to participate in by Eugene T. Pendergrass, President. He's still alive, and Professor Emeritus of Radiology at the University of Pennsylvania in conjunction with the late Stanley Rimond (?), who was deep in cancer research at Lankenau, the research center up north here. In the suburbs, you

know? And also, he was Mr. Cancer, I think, in the Pennsylvania cancer effort, generally. These two wonderful men -- both of them. And so we launched off of that using tincture of colchicum with radiation therapy. Well, that was a good idea, but the tincture of colchicum upset the gastrointestinal system of the patient, and so forth and so on. And there are other experiments that we tried, usually at the urging of recognized authorities. It wasn't quackery at all, and the patients knew what we were doing, what we were trying to do, and they all had to agree to it. And they did. They did. Very well. I'm sorry Dr. Wheeler is not here in person to share in this because he had some very wonderful times together. We had other experiments that we tried, and long research. Simple research -- not sophisticated research, but clinical research -- which wold be interesting because any of these things that we tried then are now being brought back into view again.

SB: For instance?

PL: Hypothermia, exposing cancer patients now to excessive temperatures. The National Cancer Institute and several centers in the country are using this. You know about that.

SB: A publication recently -- Popular Press got hold of last Sunday, about the use of microwaves.

PL: Oh, yes.

SB: It happens that I know socially the physicians working on that, and he's quite optimistic about the microwave.

PL: Well, listen. What I am talking about is total body.

SB: Yes.

PL: Total body. Temperatures carried out up until about 108 degrees, and that sort of thing. I mentioned Dr. James Duffy to you at Memorial. Well, while I was there -- oh, it must have been -- we'll say, for example, about 1934 or 1935. He was very excited one morning when I came in, and he said, "Look at

that." He had a beautiful piece of imported German equipment, which was a heat producer. Do you know what I'm talking about?

SB: Yes, I think so.

PL: It was a diathermy system. But this one would deliver much more effectively, and at better depth levels in anything he had. So then he was then beginning -- this was his experiment in the use of heat in conjunction with radiation therapy. Now, long about the same time here in the city -- maybe a little later -- a year or two later, maybe, but I'll say the mid-1930s -- I'll have to check the date. At Temple University Hospital, Dr. Temple Fay, the well-known neurosurgeon, was using freezing methods. Now, the development of the freon gas and the modern refrigerator began to show its effects in medicine, you see? So he was practically hibernating patients to see if that would benefit the patient with an advanced cancer. In back of that is always the clinical observations that certain malignancies --

lymphomas on the one hand or epithelial tumor or carcinoma on the other, or connective tissue tumor -- would show different patients here will show different responses, according to the season and the year. In some instances, the lymphoma group would be better in hot weather, and in some instances, it would be better in cold weather. We couldn't get the season to fit the pattern and disease exactly, but we could anticipate that the environmental effect or the environmental factor would, in some way, affect this patient with a tumor. Particularly when it was more or less of a system order or widely metastatic. We still don't know why, but it still happens right now. That's enough for today. I've run out of juice.

SB: I think we've about run out of tape, too. [laughs]

End of Interview

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